Child and Family Services Update

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Keeping Children Attached Through Transitions

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Assessing And Treating Reactive Attachment Disorder

There has been quite a bit of news in Utah lately about attachment disorders in children and therapy for reactive attachment disorder. There is some concern among many mental health professionals about the diagnosis of Reactive Attachment Disorder (RAD) being the current "fad of the day" for children in out-of-home care and adoptions.

Actually, there really is a DSM IV diagnosis of RAD that relates to children who while under the age of five have been severely deprived of maternal care. This includes some children who have had problems or severe disruptions in their early relationships. Many have been physically, emotionally, or sexually abused. Others have experienced episodes of prolonged isolation or neglect. In some cases they have multiple or traumatic losses or changes in their primary caregiver.

In May of 2002 the American Psychological Association (APA) issued the following position statement: "The recommendation to determine whether a child can accurately be diagnosed with RAD includes a comprehensive psychiatric assessment to distinguish RAD from other developmental disorders, such as autism." The Association goes on to state: "While some therapists have advocated the use of so-called coercive holding therapies and/or "re-birthing techniques," there is no scientific evidence to support the effectiveness of such interventions. In fact, there is a strong clinical consensus that coercive therapies are contraindicated in this disorder. And unfortunately, as recent events attest, such unproven and unconventional therapies can also have tragic consequences."

The Utah Division of Mental Health, the Division of Health Care Finance, and the Division of Child and Family Services support the above APA position, and have excluded coercive holding therapies from any services we will provide, support, or fund. We urge a comprehensive assessment, including a competent psychiatric assessment when determining if a child has RAD.

Transitions Create Attachment Issues For Children And Families

Often, the attachment issues we see in our child welfare system have to do with children who have been transitioned into a number of different settings, where their trust in caring adults has been severely damaged by either birth parent neglect or abuse, or by multiple placements with a number of caregivers. Many child welfare experts currently view most of these attachment issues not as disorders in the child needing therapy, but normal, expected reactions to grief and loss. The previous losses of stable, caring relationships result in an inability to bond into a new, trusting relationship, usually based upon fear of still another painful rejection or loss. Therefore, contrary to some schools of thought, many of the symptoms we see in

children related to attachment may have resulted as much from the removal and placement (often multiple placements) of a child in the state's system, as from the possible abuse or neglect they may have suffered by their parents.

Attachment Occurs In Families Not Therapy

Our Child and Family Services Practice Model has us look at a child's needs and explore the nurturing responses we should be providing to the child, not just the obvious behaviors we need to try to control or react to. We know from experience that transitions are one of the major reasons for acting out behavior in children in our system. They don't trust or believe there will be a trusting, lasting relationship. We contribute significantly to that problem when we do poor transition work with children and families. Therefore, in the case of attachment, we need to understand how poorly handled transitions in our system contribute to a child's attachment problems, and, conversely, how well handled, child focused transitions can facilitate good attachments for a child in their previous and current relationships. Rather than just seeking attachment "therapy" for a child's disorder, we need to pay careful attention to how we can preserve and nurture the significant attachments a child previously had, now has, or is attempting to form in his life. We must become far more "proactive" in creating nurturing transitions that help a child maintain his previous attachments while facilitating the new attachments. This is done within the child's family systems, not just with the child in an isolated therapeutic setting. It involves helping remove blame from both the child and parents for the attachment challenges, and helping to facilitate positive interactions between the child and parents that build on their strengths and lead to a positive relationship and bond over time. The attachment challenge is a shared condition of their circumstances they can work through together, not a disorder in either the child or the family.

Building Attachments During Transitions

In looking at what has worked for families and children, some of the following guidelines can help facilitate better bonding between children and their families through transitions. Remember that the transitions present the best opportunities to address and build the bridges of relationship.

1. Help the child and family anticipate the needs during the transition period and facilitate a discussion of the child and family strengths and needs.
2. Understand that there is no such thing as a "honeymoon" period. Begin immediately in child and family team meetings to develop the working agreement, including the crisis plans (what can go wrong) to handle the issues that may arise in family relationships.
3. Parents need to understand their own attachment issues and their impact on the children placed with them. Children are incredibly resilient, and positive parenting interactions will have a huge impact on their bonding processes in the family.

4. Support the parents who are feeling rejected by the child's withdrawn or acting out behavior. Parents can be helped to understand and anticipate the child's needs underlying the behavior, and to not feel diminished or discounted as a parent because of it. Triggers of the behavior can be anticipated and supports developed for the child to avert the issue, or to help manage the behavior in a nurturing, supportive way. Then, for example, when a child says, "I wish I were never adopted" the adopting parent can (ego set aside) listen, empathize, and allow the child to mourn the loss of his birth parents, without being threatened or wounded.
5. Involve siblings and extended family, as appropriate, in the family team meetings, involving their strengths, assessing their needs in the interactions, and nurturing their bonding with the parents and adopted child.
6. Staff competent in adoption issues, who understand a child's developmental level, level of understanding, and underlying needs should help facilitate the process.
7. Workers and parents should put their own needs aside and pay attention to the child. Facilitators need to look through the challenge, not the damaged lens at both the parent and child, and put the best interest of the child above all else.
8. Treat the "real" mental health issues of a child, but do not "pathologize" the normal reactions to the transitions, such as grief and loss, divided loyalties, identity crisis, and other predictable adoption issues. Labeling a child as disordered because of his adoption related issues is a great disservice to the child and family. Avoid therapists and therapies that make the child and their adoption issues more pathological than they really are.
9. Avoid experimental therapies. Parents want to believe in them because of promises they make for a cure, and they often focus mainly on the child. Stay with more proven cognitive and family systems approaches that have proven to work over time.
10. Help families maintain realistic expectations for relationships, and understand what levels of attachment they might anticipate, without "selling a child or family short" on how much they might achieve together. Patience, time, and positive shared experiences are the key to success in any parent/child relationship.
11. Encourage the child to tell their adoption story often to the worker and the therapist. There is a great deal of power of the story to heal the storyteller.
12. Honor the adopted child's birth family and origins. The positive feelings a child has about his birth parents allow a more positive self-concept and increased self-esteem. If the child is of a different race or culture, connect the child (and your whole family) to those communities and the sense of

pride that creates. This is essential to good bonding and attachment in current relationships.

13. Keep the family informed of adoption support networks, respite care opportunities, and other resources to assist them to be successful. Identify at least one person they can call for support when overwhelmed.